

Medicaid Managed Care: The Changing Landscape

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MOVING FORWARD >>>

TOGETHER

In a New Era of Health Care

Florida Medicaid

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Florida Medicaid Director

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Florida CHAIN Annual Conference

September 18, 2015



Florida Medicaid

- Florida Medicaid provides access to health care for low-income families and individuals and also assists aged and disabled people with the costs of nursing facility care and other medical expenses.
- Most Florida Medicaid recipients are enrolled in one or both of the components of the Statewide Medicaid Managed Care (SMMC) program:
 - Long-term Care program
 - Managed Medical Assistance program.



SMMC Program Goals

- The goals of the Statewide Medicaid Managed Care Program are:
 - Improve coordination of care
 - Improve the health of recipients, not just paying claims when people are sick
 - Enhance accountability
 - Allow recipients a choice of plans and benefit packages
 - Allow plans the flexibility to offer services not otherwise covered
 - Enhance prevention of fraud and abuse through contract requirements.



SMMC Program Design

- Plan Choice
 - Choice Counseling
 - HMOs and PSNs (provider service networks)
 - Comprehensive Plans
 - Specialty Plans in MMA
 - Accredited Plans
- Added Benefits
 - Choice of Benefit Package
 - Expanded Benefits
- Enhanced Access
- Enhanced Quality Measures
- Increased Transparency
- Risk Adjusted Rates



Plan Choice

- In addition to the availability of standards plans and comprehensive plans, the following specialty plans types are available under the MMA component of the SMMC program:
 - Child Welfare
 - Children’s Medical Services Network
 - HIV/AIDS
 - Serious Mental Illness



Plan Choice

- MMA Plan Accreditation
 - Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed.
 - For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment.



Added Benefits

- Expanded Benefits:
 - The Agency negotiated with health plans to provide extra benefits at no cost to the state. These benefits include:
 - Adult dental
 - Hearing and vision coverage
 - Outpatient hospital coverage
 - Physician coverage, among many others.



Enhanced Access

- Network Adequacy Standards
 - Time and distance standards
 - Ratios of patients to providers
 - Increasing the number of primary care and specialist providers accepting new Medicaid enrollees
 - Increasing the number of primary care providers that offer appointments after normal business hours
 - Extremely low level of complaints/issues.



Enhanced Access: Increased Physician and Dental Provider Participation

Dental Providers	November 2013	June 2015	Total % Change from Nov-2013 to Jun-2015
Total Participating FFS Fully Enrolled MDs and Dos	35,317	37,076	4.98%
Total Participating Registered MDs and Dos	4,382	5,573	27.18%
Total Participating MDs and Dos	39,699	42,649	7.43%
Total Participating FFS Fully Enrolled Dentists	1,414	1,544	9.19%
Total Participating Registered Dentists	470	775	64.89%
Total Participating Dentists	1,884	2,319	23.09%

Source: These data were pulled from the monthly DSS provider enrollment reports.



Enhanced Transparency

- Centralized Complaint Hub:
 - Allows the Agency to streamline and better track and respond to all complaints and issues received.
 - Provides a mechanism to review trends in related to specific issues, or complaints against specific plans.



Enhanced Transparency

- SMMC Quarterly Reports:
 - The Agency is releasing a series of quarterly reports that will provide up-to-date information on the progress of the SMMC program.
 - The first two quarterly reports are available on the Agency’s website.
 - The Agency will continue to provide analyses of the program through these reports that will provide insight into:
 - the program’s cost effectiveness
 - quality of care, and
 - other significant aspects of the program.



Enhanced Transparency

- Health Plan Report Cards:
 - Enrollees can now choose plans based on quality.
 - In the early part of 2015, Medicaid began publishing a consumer-focused Medicaid health plan report card.
 - The report card includes ratings on how Florida's health plans are doing on getting children into well-child visits and to dental care.



Enhanced Quality

- Encounter Data:
 - Encounter data are electronic records of services provided to Medicaid enrollees by a capitated health plan.
 - Encounter data are submitted in a federally-mandated HIPAA-compliant format from health plans to the Florida Medicaid Management Information System.
 - The Agency has collected encounter data since 2008, but the data will be used more prominently in the SMMC program.
 - The Agency will use encounter data to monitor plans on a variety of metrics to ensure performance and quality measures are being met.



Enhanced Quality

- HEDIS Data and Information Set:
 - HEDIS = Healthcare Effectiveness Data and Information Set
 - HEDIS is the National Committee for Quality Assurance’s (NCQA) standardized set of performance measures.
 - Used by over 90% of health plans in the U.S.
 - Detailed technical specifications ensure that measures are calculated consistently.
 - Allows “apples-to-apples” comparison of health plans.



Enhanced Quality

- HEDIS Audit:
 - NCQA certifies HEDIS auditors who must review the health plan's capability for collecting, storing, analyzing, and reporting health information.
 - HEDIS auditors determine if health plans have followed the HEDIS technical specifications and Agency requirements for performance measures.
 - The Agency requires that health plans undergo a HEDIS audit by a certified auditor and submit a final audit statement along with their performance measure report.



Enhanced Quality

- HEDIS National Means and Percentiles:
 - Published by NCQA annually.
 - Reports national benchmarks and thresholds for HEDIS measures.
 - Includes 10th, 25th, 50th, 75th, and 90th percentiles
 - The Agency also calculates the 40th and 60th percentiles for our use
 - Calculated based on data from all health plans who report data to NCQA for the previous calendar year (e.g., 2014 national means and percentiles are calculated using calendar year 2013 reported data).
 - The Agency compares each health plan's performance measure rates to the HEDIS national means and percentiles.
 - For each measure where the health plan's rate falls below the 50th percentile, the plan may receive liquidated damages.

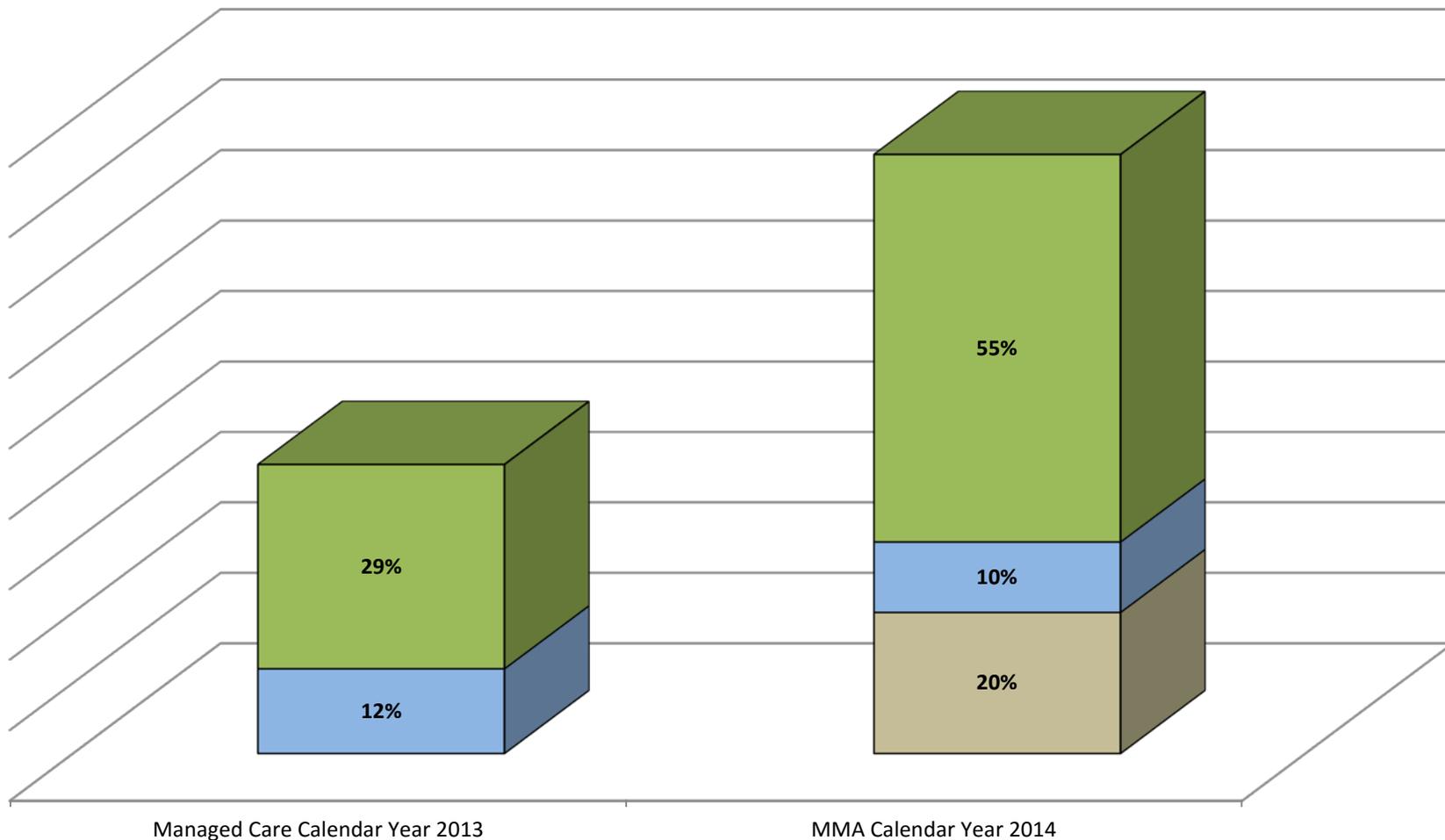


Enhanced Quality

- Determining HEDIS Scores:
 - Florida Medicaid health plans submit their eligible member, denominator, numerator, and rate data for measures predetermined by the Agency for the previous calendar year by July 1 of each year.
 - Scores for each measure are aggregated to come up with a weighted mean for all Florida Medicaid health plans.
 - For HEDIS measures that health plans are required to report to the Agency each year, plans are to refer to the current year's technical specifications manual which includes information on how to calculate the eligible population, denominator, and numerator based on diagnosis codes and other factors.



Enhanced Quality: HEDIS Compared to the National Mean



Managed Care Calendar Year 2013

MMA Calendar Year 2014



■ Scores better than the National Mean

■ Scores at the National Mean

■ Scores below National Mean in calendar year 2014, but higher than managed care scores in calendar year 2013

Note: If non-reform and Reform are separated when calculating the percentage of “the scores below the National Mean in calendar year 2014, but higher than managed care scores in calendar year 2013”, the overall percentage would be 14%.

2015 Florida CHAIN 1st Annual Conference
“Moving forward together in a new era of health care”



Medicaid Managed Care: The Changing Landscape

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September 18, 2015, 10:30-11:45 a.m.



Perspective #1

4/96

Perspective #2 – Background shapes experience

- **4,000+ SSI/SSDI hearings between 1974 and last week**
- **Per Florida Statute, SSI triggers Medicaid eligibility**
- **Concentration of work in Special Needs Trusts**
- **ACA – early student and adopter during PCIP**

Perspective #3 – Things I am not

- A medical provider
- An attorney who represents providers or insurers
- A health care patient attorney doing insurance appeals
- A researcher funded to examine health care policy

However, I am, with ACA, committed to move my disabled clients out of Medicaid to private health insurance whenever possible because of my experience. Why?

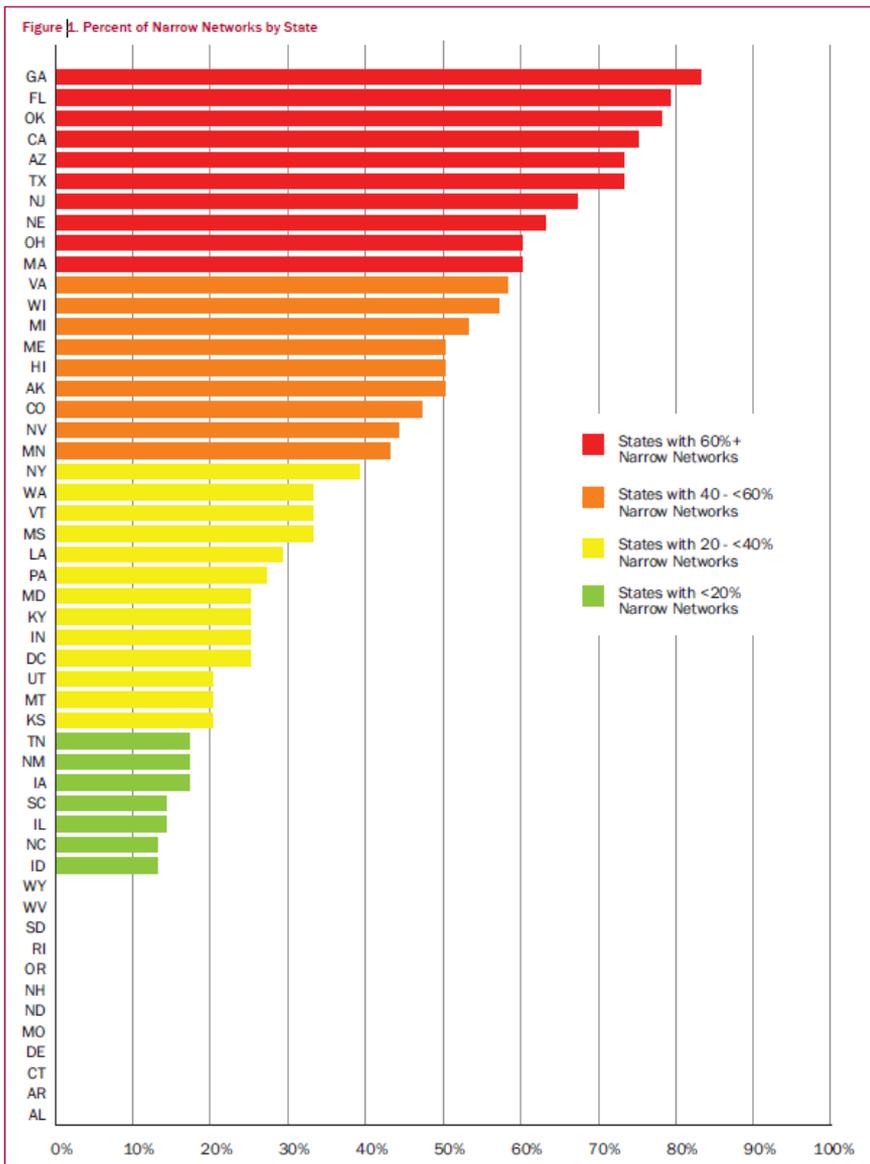
The Main Problems with Medicaid MCOs: even more narrow physician networks than before

- This problem shared with ACA bronze and silver plans
- Lack of transparency to consumers who are given choices without information upon which to choose
- Complicated systems: BCBS ≠ BCBS ≠ BCBS
- “List of Providers” often not accurate, nor up to date, and fails to identify those not taking new patients

States with the narrowest networks from worst at top to best at bottom

Where does Florida rank?

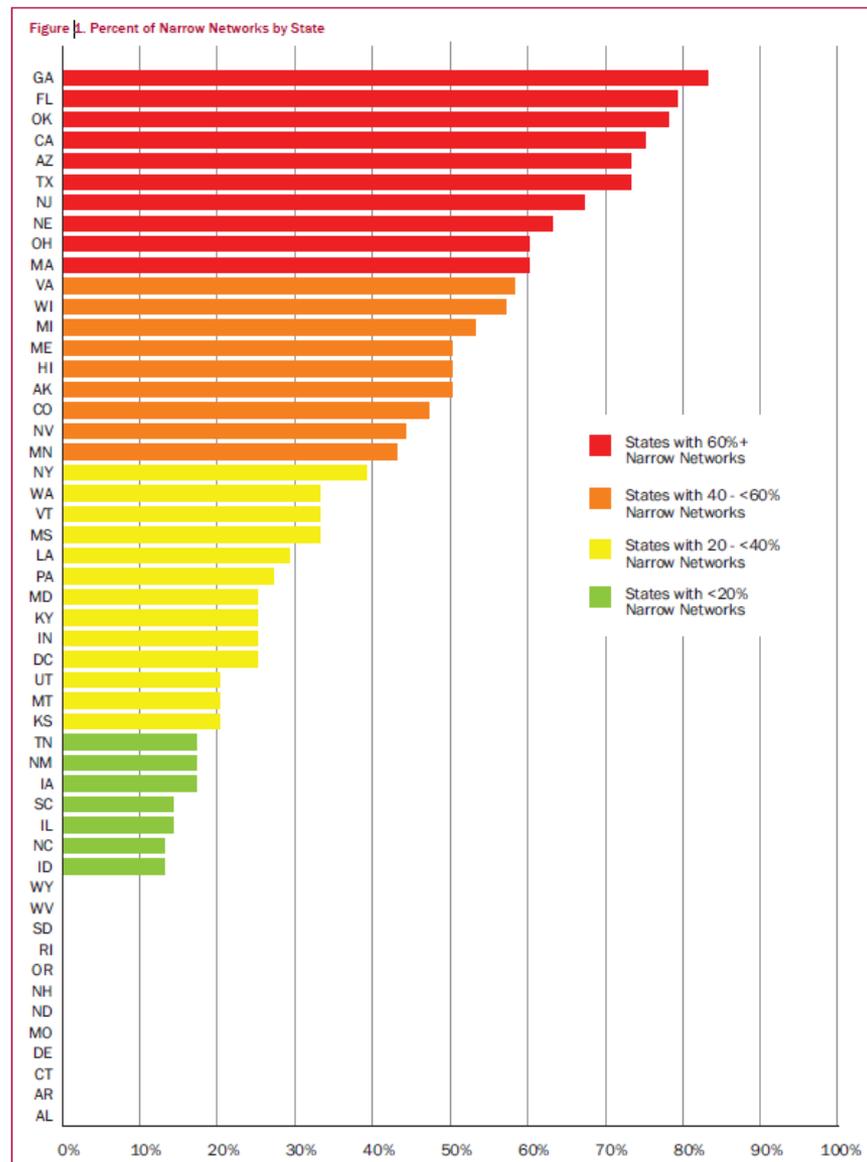
August 2015 Penn Institute of Health Economics Study



States with the narrowest networks from worst at top to best at bottom

Florida is 49th worst of the 50 states

August 2015 Penn Institute of Health Economics Study

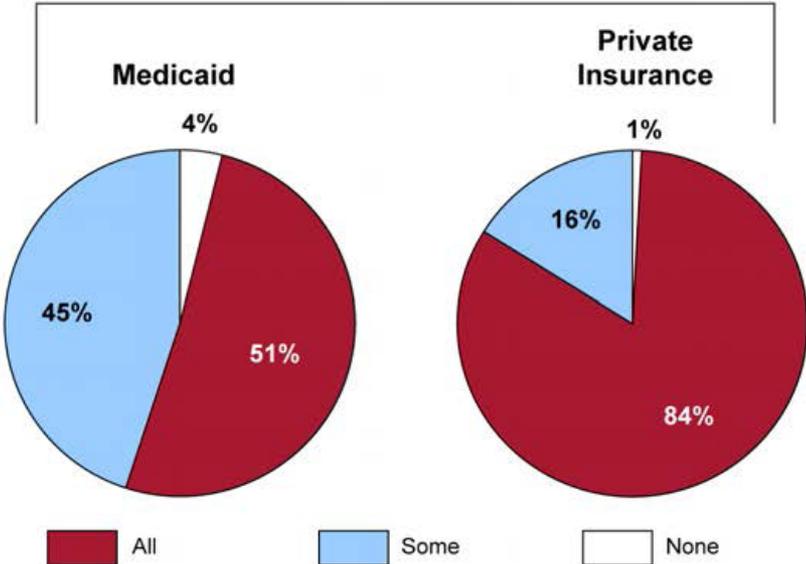


4%/96%

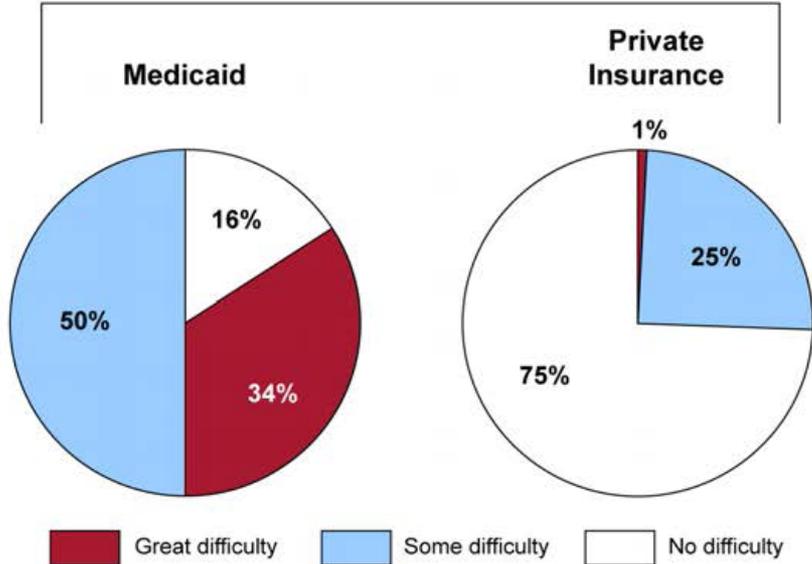
- **Capitated managed care systems defined as payments made by the state to MCOs on a “predetermined, per person per month basis.”**
- **4% overall report difficulty getting medical care or prescriptions**
- **21% only sometimes or never easy to see a specialist**
- **More physicians report difficulty referring Medicaid-covered children and adults to specialists than privately insured persons – surgical specialties, OBGYNs, and pediatricians**

Lillesand, Medicaid Managed Care: The Changing Landscape

Specialty care physicians' acceptance of new patients



Difficulties with specialty referrals



Source: GAO. | GAO-15-677

Dr. Marcy Howard (Crystal River, FL): “It’s spiraling out of control. There’s a shortage of pediatricians and pediatric specialists because there’s no financial return.” Her MCO reimbursement of urinalyses and hemoglobin tests are less than her out of pocket costs to get them. She often directs her patients to Orlando for specialists because there are no closer options. *Tampa Bay Times*, September 8, 2015.

Secondary Problems for attorneys advising clients:

- **Lack of access to complete information**
 - Data on capitation cost
 - Lack of confidence in provider lists
- **Capitation cost data is necessary for attorneys to do accurate cost-benefit analysis of SNTs versus ACA to move patients from Medicaid to private health insurance**

Prevalence and Cost of Managed Care

“...as of 2011, nearly 75% of Medicaid beneficiaries received services through some type of managed care arrangement...(and) are now enrolled in capitated managed care plans, including Managed Care Organizations (MCO’s), which receive a fixed per-member, per-month “capitated” fee, regardless of how many services an enrollee may actually need.”

- Turner, Machledt & Somers, “A Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care,” NHeLP, March 2015.

**The typical private contract dollar amount =
\$3,800 per member per month (\$45,600 per year)**

But is Medicaid truly free in a Medicaid Managed Care State?

- What is “Managed Care” vs. Fee-for-Service?
- What is the true cost to the individual?
- What is its cost to the individual when terminating the SNT or to the heirs of the individual at the beneficiary’s death?

What hasn't changed with Medicaid

1. Medicaid Estate Recovery and Special Needs Trust Liens at death
2. The growing trend among the states to Medicaid Managed Care, not just Florida
3. The growing post-death repayment costs of Medicaid Managed Care liens

Other than cost, remaining issues

Medicaid with SNT

- Loss of control of finances
- Sole benefit rule – inability to easily share \$\$ with family
- On-going re-certification of eligibility for a welfare program
- Medicaid limits

Private Health Ins.

- Choose your own ins.
- Change it annually if not satisfied with the private carrier
- Wider range of doctors
- No annual or lifetime caps
- The most disabled person can get the best insurance there is – just like you and me

But is Medicaid truly free in a Medicaid Managed Care State?

- What is “Managed Care” vs. Fee-for-Service?
- What is the true cost to the individual?
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Real Life Example – Establish SNT

19 year old football star, lost both legs, \$2 Million settlement, should we establish an SNT to get “free” Medicaid in Florida.

Healthy and strong. History reveals he only saw the doctor three times for flu shots in 10 years before he died in an unrelated accident.

What was and is his true cost to have Medicaid?

What did the three flu shots cost him?

Cost to Participate in Medicaid vs. Private Health Ins.

Cost-Benefit Analysis: \$2 Million settlement

Establish SNT?

- \$5,000 One time Attorney fee
- \$2,500 Monthly trustee fee at standard 1.5%
- Annual CPA Trust Tax Prep fee - \$800

“Free” Medicaid

Purchase Private Insurance?

- ZERO attorney fee
- \$129 Monthly premium cost
- Annual \$2,000 Out-of-pocket max

For the best health insurance money can buy

SNT Plan Costs:

- Establish SNT = \$6,500 attorney fee
- Trustee fees = \$300,000
- Medicaid lien at death - \$3,800/month capitation rate times 120 months (10 years) = \$456,000 for three flu shots

TOTAL COSTS = \$762,500

for three flu shots

Purchase private insurance (no SNT):

- Establish SNT = \$0 attorney fee
- Trustee fees = \$0
- Lien at death for medical care = \$0
- Premiums over ten years life = \$15,480
- Maximum out-of-pocket = \$20,000

TOTAL COSTS = ~~\$762,500~~ \$35,480

Second reason to move my disabled Medicaid Managed Care clients with assets to private health insurance whenever possible

To get the best “rich persons’ insurance” with:

- Broadest network possible
- Best doctors and hospitals
- Most reliable insurance companies
- Opportunity to change insurers annually

A few examples from the last 6-8 weeks of problems with Medicaid Managed Care access, other than cost:

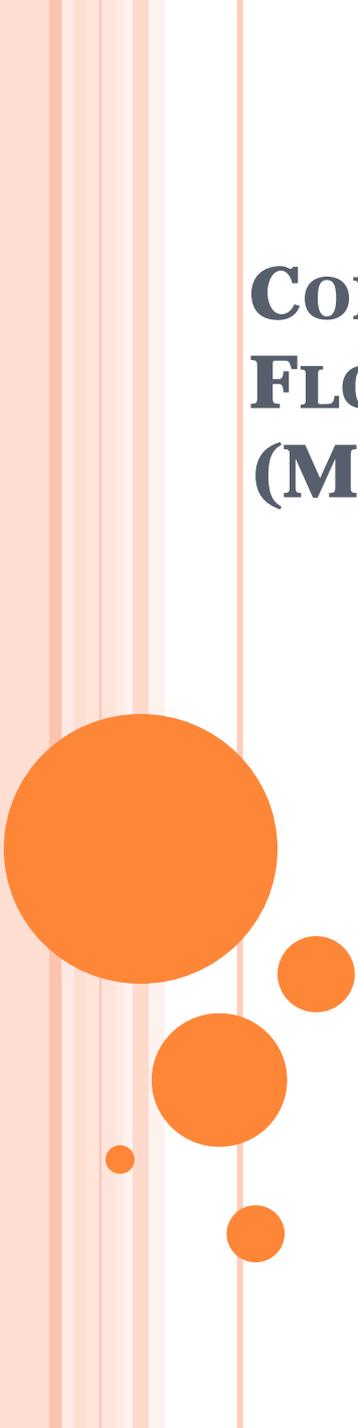
- **Palm Coast woman could not get urologist within 100 miles of her home**
- **Fort Myers child on respirator and G-tube**
- **Pasco county Registered Nurse mother with adult TBI son**
- **Tampa Bay client needing lumbar spine surgery**

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Thanks for listening.

Ready for Questions and Discussion

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CONSUMER PROTECTIONS IN FLORIDA'S MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM

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**Florida CHAIN Annual Conference
September 18, 2015**

NETWORK ADEQUACY & TIMELY ACCESS

- MMA Health Plans must have sufficient and accurate provider networks under contract and taking patients
- Provider Network Adequacy requirements include standards on time and distance beneficiaries must travel to primary care providers and specialists;
- Timely Access to Care:
 - Urgent Care – within one (1) day of the request
 - Sick Care – within one (1) week of request
 - Well Care Visit – within one (1) month of request

ENROLLMENT PROCEDURES

- Choice Counseling
 - www.flmedicaidmanagedcare.com or
 - 1-877-711-3662
- Recipients have 90 days after enrolling in a plan to choose a different plan;
- After 90 days recipients can change plans with a state approved good cause reason;
- Auto-enrollment (when beneficiaries fail to choose a plan and are then assigned a plan) takes into account individual circumstances.

QUALITY OF CARE REQUIREMENTS & PLAN REPORTING MEASURES

- Comprehensive State Quality Strategy
- Performance targets that equal or exceed the 75th percentile national Medicaid performance level
- Performance Improvement Projects
 - Improved prenatal care
 - Well-child visits to age of 15 months
 - Preventive dental care for children
- Health Plan Report Cards

MEDICAL LOSS RATIO (MLR) REQUIREMENTS

- MLR measures percentage of premium dollars a plan spends on medical care compared to administrative costs;
- Florida's Medicaid Managed Care Plans are required to maintain MLR of 85%;
- First time federal CMS has included an MLR requirement in a waiver agreement.

OPPORTUNITIES FOR STAKEHOLDER INVOLVEMENT & INPUT

- Medical Care Advisory Committee
 - Must include 4 beneficiaries

<http://www.fdhc.state.fl.us/medicaid/mcac/index.shtml>
- Subpopulation Advisory Committees
 - HIV/AIDS
 - Managed Long-term Care services
 - Children, especially those in foster care
 - Dental care for children
 - Behavioral Health and Substance Abuse
- AHCA public hearings and Medicaid Alerts
 - public hearings: <http://www.fdhc.state.fl.us/Calendar.shtml>
 - alerts: <http://www.fdhc.state.fl.us/Medicaid/alerts/alerts.shtml>
- AHCA SMMC Complaint Hub:
https://apps.ahca.myflorida.com/smmc_cirts

COMPLAINTS, GRIEVANCES & APPEALS/FAIRING HEARING PROCESS

- **Complaints - can be made to:**
 - AHCA through the SMMC complaint process about any SMMC issue
 - Health Plans for problems that haven't reached grievance or appeal level
- **Health Plan Internal Grievance and Appeal Process**
- **Medicaid Fair Hearing – Beneficiaries has a right to appeal through a Fair Hearing process when services are denied, reduced, or terminated**
 - At this time, no need for beneficiaries to exhaust Health Plan grievance and appeal process first. Likely to change.

CONCERNS & AREAS TO MONITOR

- General lack of awareness or clear understanding of important consumer protections (e.g. timely access standards)
- Inaccurate information provided to Beneficiaries:
 - Health plan provider directories
 - Inadequately trained staff
 - Spreading of managed care urban myths
- Some of the most important consumer protections can be the hardest to monitor
 - Difficult to track or address some problems unless they are reported
 - Adequate monitoring requires “secret shopper” type programs
 - Increased consumer education necessary so beneficiaries (and all stakeholders) can recognize and report problems

INCREASED EDUCATION AND OUTREACH

- **Create a section of the AHCA website dedicated to SMMC consumer protection and quality of care issues**
- **Include Health Plan Report Cards in the Choice Counseling materials and link to quality of care and performance reports from Choice Counseling website**
- **Consumer Alerts – establish a system similar to Medicaid Provider Alerts to update consumers**
- **Make sure health plan customer service reps. and other staff on the front lines are well-trained and providing consumers with accurate information**

WHEN CONSIDERING CONSUMER PROTECTIONS DON'T FORGET THE BASICS!

- Health Plan Member Handbooks provide critical information and should be first place to go when problems come up
- Encourage beneficiaries to know and build a relationship with their Primary Care Provider
- Make use of health plan services such as Case Management Programs and learn about Plan specific programs
- Ask questions, report problems, and share experiences.

**For additional information or assistance,
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